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Division of Health Care Financing and Policy
Notice of meeting to solicit public comments and intent to act
Upon Amendments to the Medicaid Services Manual (MSM)
Public Hearing September 3, 2015
Minutes

Date and Time of Meeting:	September 3, 2015 at 9:00 am
Name of Organization:	State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP)
Place of Meeting:	Nevada State Legislature Building 401 So. Carson Street Room 2134 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue Suite 4412E Las Vegas, Nevada 89101

Attendees

In Carson City, NV

Kathy Stoner, DHCFP
Marti Cote′, DHCFP
Sue Sutherland, Renown Health
Lynne Foster, DHCFP
Tammy Moffitt, DHCFP
Carl Jeffrey, Optum
Kevin Whittington, Optum
Bonnie Long, DHCFP
Mary Griffith, DHCFP
Coleen Lawrence, DHCFP
Lori Mariluch, Renown Health
Darrell Faircloth, Senior DAG
Elizabeth Aiello, DHCFP
Parker Stremmel, Ferrari Public Affairs
Alex Zom, Optum

In Las Vegas, NV

No Attendees

Introduction:

Ms. Tammy Moffitt, Chief of Program Integrity, Division of Health Care Financing and Policy (DHCFP), opened the Public Hearing introducing herself, Ms. Betsy Aiello, Deputy Administrator of the DHCFP and Mr. Darrell Faircloth, Senior Deputy Attorney General (DAG).

Ms. Moffitt – The notice for this public hearing was published on August 3, 2015 in accordance with the Nevada Revised Statute 422.2369.

1. Public Comment

- No Comments

2. For Possible Action: Review and approval of meeting minutes from the August 13, 2015 public hearing.

Ms. Moffitt - The DHCFP staff were asked if they had any proposed revisions or corrections to the minutes and there were none received.

Public Comments

- No Comments

Ms. Moffitt – Recommended the Deputy Administrator approve as written.

Ms. Aiello – Approved Meeting Minutes from August 13, 2015.

3. For Possible Action: Discussion and Proposed Adoption of the Business Associate Addendum Form

Ms. Lynne Foster:

Revisions to the Business Associate Addendum form are being proposed to remove an obligation on the part of business associates to report inappropriate DHCFP practices.

The effective date is September 4, 2015.

At the conclusion of Ms. Foster's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello Comments:

- No Comments

Mr. Faircloth's Comments:

- No Comments

Public Comments:

- No Comments

Ms. Moffitt – Recommended the Deputy Administrator approve this form as written.

Ms. Aiello – Approved Proposed Changes to the Business Associate Addendum Form.

Ms. Moffitt – Closed the Public Hearing for the Business Associate Addendum Form.

4. For Possible Action: Discussion and proposed adoption of changes to MSM Chapter 200 – Hospital Services

Ms. Kathy Stoner:

Revisions to MSM Chapter 200 are being proposed to specify that providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure, deny coverage of the one inpatient day during which sterilization is performed without a valid sterilization consent form, cover medically necessary inpatient days within the same episode of care that are not the day the sterilization procedure was performed without a valid prior authorization, and define the term, episode of care. A revision was also made to clarify coverage of non-emergency services provided in an emergency room.

The effective date is September 4, 2015.

At the conclusion of Ms. Stoner's presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

Ms. Aiello's Comments:

- No Comments

Mr. Faircloth's Comments:

- Please confirm the effective date.
- Ms. Stoner stated the effective date is September 4, 2015.
- Mr. Faircloth inquired if these changes are clarification of existing policy.
- Ms. Aiello stated I believe the sterilization form currently, the whole incident of care is denied when the form was not obtained, is that correct.
- Ms. Stoner responded yes, that is correct.
- Ms. Aiello stated therefore, it is a policy change that is now denying the one day instead of the whole incident of care day.

- Ms. Stoner responded it allows the other days to be reimbursed.

Public Comments:

- Sue Sutherland from Renown commented on the Sterilization Section, page 16, number 16. I believe there is a technical correction that needs to be made it reads "Reference MSM Chapter 600, Attachment B, Sterilization Consent Form" I believe this was removed from the Chapter at one of the last sessions and there is no longer an Attachment B.

- We appreciate that Medicaid recognizes that when we have a tubal ligation that is done within a Cesarean Section period of time that the entire stay should not be denied, however we still are concerned that a procedure has now been entered into it as part of the contingency for payment for per diem payment schedule. One of the examples that we come up against quite often is during a Cesarean Section, a tubal ligation may be performed and at that time patients may not necessarily be on a governmental program, they may apply for Medicaid after the fact and have retro coverage so at the time they were going through their prenatal stage or going through that coverage, there was no requirement for a federal consent form. All hospitals, as you know, always get an informed consent, so that consent is on file before any procedures are rendered. Our concern though is that now denying the Cesarean Section day, which is a valid procedure, that has been performed and for the per diem reimbursement it is for maternity. We more or less have taken that one day of maternity away from the providers.

- We are very happy that now the whole stay is not being denied, but there still seems more that needs to happen. I understand that there was a workshop that took place, but I was not able to find the information on that workshop. If this has been covered elsewhere I apologize. I need some further clarification that perhaps we could get answered today. With this statement that is out there, can a provider elect to remove the tubal ligation charges from the maternity claim and submit the claim as only a delivery claim? If that is something that would be allowed. I am not sure from the language that was entered into the chapter that it is allowing the provider to make that decision. The other concern I had was the statement that reads "providers must ensure valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure." I would like reassurance that this statement is in regards to a reimbursement part and does not open up a hospital or provider for any SUR reviews that might take place regarding performing a procedure without a federal consent form. I want to make sure that it is not going beyond the claim and payment process by that statement in that manual.

- Ms. Stoner responded of course Medicaid cannot instruct a provider how to bill, we cannot advise a provider to leave off a claim for the sterilization portion, so we cannot advise how you should bill that.

  The issue regarding the SURs, if the form does not meet the federal requirements and a SURs audit were to be performed on that claim, we could not tell you it would not be recouped if the claim had been paid.

- Ms.Sutherland stated that is mostly the assurance I was going for. That this is more of a reimbursement than a clinical. The concern would be that because a sterilization procedure was

performed and the hospital did not obtain that form. I just want to make sure the statement does not go beyond a claim process it is totally referencing the claims process.

- Ms. Stoner replied from a perspective of this is what it is. It is reimbursement and if the consent form does not meet all the federal requirements, the claim would not be reimbursed to begin with.

- Ms. Sutherland stated I just wanted to make sure it is dealing with the claim and reimbursement process and not looking at any other integrity issues of a hospital or provider that could be seen as service wise or clinical wise.

- Coleen Lawrence responded this is not a change in policy as far as what the federal requirements are for the sterilization requirements; this is based upon what is required in the code of federal regulations. What is required based on the code of federal regulations has not changed. It is the provider's responsibility if sterilization is performed, the sterilization form is required. It is also the provider's responsibility to detail all of the procedures that are performed on the date of service, so if sterilization is performed, it must be detailed out on that claim form. This does not change on this policy; it must be detailed out on each claim. As far as pulling out that sterilization on the claim, at the present time as long as we have a per diem rate methodology, we cannot pull out the sterilization charges.

  You are more than welcome to work with the state to see if we want to modify our reimbursement methodology together. At this point in time we do not. A workshop was held and Renown was a participant. This is why we have a policy change, because Renown specifically came to us and told us that they wanted us to modify our procedures on how we are handling the sterilization form and this policy is the outcome of our last workshop, so our best outcome that we had at this point in time, based upon a per diem rate methodology was to not pay the one day which was the date of service the sterilization was performed, but to be able to pay the surrounding days, so this is our middle ground we have right now with a per diem rate methodology. As a summary, if sterilization is performed, the sterilization must be reported on the claim, a sterilization form must be submitted with the claim that meets all the federal requirements, if we want to continue to work together and see if we can do a different rate methodology in the future that does not detail out a per diem, but details out the separate charges it will take a change in our system as we talked about it with our Medicaid Management Information System. We can work together on that in the future and we would be happy to have future workshops to work through that.

  There is a technical clarification that does need to be removed. We do need to strike that language "Reference MSM Chapter 600, Attachment B, Sterilization Consent Form"; there is no longer that reference.

- Mr. Faircloth inquired is that making reference to the Sterilization Consent Form which the paragraph says "In chapter 600 Attachment B", but there is no Attachment B at this point. Is that the correct understanding.

- Ms. Lawrence replied that is correct. As the representative from Renown pointed out that is an incorrect reference that was removed in a previous public hearing, so that reference is no longer

the correct reference. All of our forms are found in our billing manual, so that reference needs to be stricken, it is not a correct reference.

- Mr. Faircloth inquired is it no longer in the service manual.

- Ms. Lawrence responded yes that is correct, it has been removed.

- Ms. Aiello inquired is it correct to leave "Reference MSM chapter 600" still in the language.

- Ms. Stoner replied no.

- Ms. Aiello inquired if "Reference Attachment B" was being removed or removal of "Reference MSM Chapter 600 Attachment B". Please read in the correct language that will be staying in the chapter.

- Ms. Lawrence responded the entire sentence should be removed "Reference MSM Chapter 600, Attachment B, Sterilization Consent Form". It should now read "Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for the specific procedures".

Ms. Moffitt – Recommended the Deputy Administrator approve with the submitted changes.

Ms. Aiello – Approved the chapter with the submitted changes to the sentence in Sterilization Consent Form, page 16, number 16 to now read "Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for the specific procedures".

Ms. Moffitt – Closed the Public Hearing for the Medicaid Services Manual Chapter 200.

5. For Possible Action: Discussion and proposed adoption of changes to MSM Chapter 1200 – Prescribed Drugs.

Mr. Carl Jeffries:

The Drug Use Review (DUR) Board is a requirement of the Social Security Act (SSA) to identify and reduce fraud, abuse, overuse, and medically unnecessary care. The DUR Board also works to minimize drug interactions, drug-induced illness, and undesirable drug reactions in recipients.

Revised and new prior authorization criteria were approved by the DUR Board on April 23, 2015. Prior authorization criteria were revised for Xolair® (omalizumab). New prior authorization criteria was established for Viekira Pak® (dasabuvir-ombitasvir-paritaprevir-ritonavir), Vivitrol® (naltrexone), Xyrem® (sodium oxybate), Vimovo® (naproxen/esomeprazole), and Rayos® (prednisone delayed release). Quantity limitations were revised for Zohydro® (hydrocodone).

The effective date is October 1, 2015.

At the conclusion of Mr. Jeffries presentation, Ms. Moffitt asked Ms. Aiello, Deputy Administrator, and Mr. Faircloth, DAG, if they had any questions or comments.

- Ms. Aiello stated with the removal of Section II the other sections were updated with lettering as appropriate.

- Mr. Faircloth stated with regard to page 87, BBB.1.b.3, you indicated there is some language you would like changed. Please read in the correct language.

- Mr. Jeffries responded there is a typo for the word anticoagulant currently reads "antigoagulant". It should read "Concomitant therapy for an anticoagulant or antiplatelet agent (including aspirin) or chronic oral corticosteroids".

- Mr. Faircloth replied thank you, I see now it was just a spelling error. On page 83 YY.1.f "The requested dose is 25/150/100 mg" in looking at that the order of those numbers suggest to me that we should double check as it may suppose to read 25/50/100 mg. or is this correct.

- Mr. Jeffries replied the dose is written correctly.

- Mary Griffith inquired when we have done public hearings it is usually the following month on the first that the chapter becomes effective. This chapter has an effective date of September 4, 2015 and I don't believe that will be enough time to let providers know about these changes. Can we change the effective date to October 1, 2015.

- Ms. Aiello agreed to have effective date changed to October 1, 2015.

- Mr. Faircloth stated from a legal perspective it is fine to delay the effective date of these regulations, of course it is always better to notice everyone up front the exact date it would be implemented. It is acceptable to delay their implantation particularly in this instance where you cannot effectively implement them for awhile.

Public Comments:

- No Comments

Ms. Moffitt – Recommended the Deputy Administrator approved with the following changes: On the MTL - Change the effective date from September 4, 2015 to October 1, 2015, Second paragraph under Background and Explanation remove extra period, under the Titles Manual Section/Section Title/Background and Explanation of Policy Changes, Clarifications and Updates - Put Manual Sections in order, In the Chapter section YY remove duplicate language of partitavir, Section YY.1.d remove the letter d form the word and to read "an" and in Section BBB.1.b.3 correct typo in the word anticoagulant.

Ms. Aiello – Approved the changes to Chapter 1200 with the corrections as read into record by Ms. Moffitt.

Ms. Moffitt – Closed the Public Hearing for the Medicaid Services Manual Chapter 1200.

6. General Public Comments

- No Comments

7. Adjournment

There were no further comments and Ms. Moffitt adjourned the public hearing at 10:02 am.

An Audio (CD) version of this meeting is available through the DHCFP Administration office. For more detailed information on any of the handouts, submittals, testimony and or comments please contact Robyn Heddy at Robyn.Heddy@dhcfp.nv.gov or (775) 684-3678 with any questions.